

DENTAL ENROLLMENT FORM

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER INFORMATION					
EMPLOYER NAME			LOCATION		GROUP NO.
EMPLOYEE					
LAST NAME		FIRST NAME			M.I.
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ()			BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
COVERAGE – Check Those That Apply					
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILDREN REQUESTED EFFECTIVE DATE: _____					
DEPENDENT INFORMATION					
SPOUSE NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /		STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? _____ IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: _____					
REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent					
I DECLINE COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILDREN REASON FOR REFUSAL: _____					
ACKNOWLEDGMENT AND AUTHORIZATION					
I hereby request coverage as outlined above under the American National Life Insurance Company of Texas group dental plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage, treatments, and services I may receive may be distributed and disclosed to my employer. I hereby consent to the dissemination and disclosure of all information. I declare all answers true and complete.					
WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.					
DATE		CITY AND STATE			
SIGNATURE OF EMPLOYEE					